A Government-Run Health Plan: Why Doctors, Hospitals, and Patients Will Lose

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In light of proposals to establish a government-run "public" health plan, the Republican Conference has prepared a Policy Brief outlining the implications of such a measure.

Summary: While President Obama and many Democrats have advocated for a government-run health insurance plan, the ramifications of its creation would be significant and far-reaching. Independent estimates suggest that such a plan could provide a strong incentive for employers to "dump" their current health insurance offerings—not because the government plan is more efficient *per se*, but because the government's "take it or leave it" philosophy of reimbursement negotiation with providers will raise costs for private insurers who remain. Congressional Budget Office Director Elmendorf recently confirmed this notion, testifying before the Energy and Commerce Committee that it would be "extremely difficult" to create "a system where a public plan could compete on a level playing field" against private coverage.[1] Creating a "public health option" could result in more than 100 million Americans losing access to their current health insurance—breaking a central promise of then-Senator Obama's campaign—while placing them in a government-run plan that could become a *de facto* single payer health insurance system.

Proposals: During his presidential campaign, then-Senator Obama proposed creating a new government-run insurance plan. While his initial plan stated the government-run plan would be open only to small businesses or those without an offer of employer-sponsored health insurance, later documents proposed opening the plan to all Americans. In either case, the plan would not deny access or raise premiums based on health status and would include a benefits package similar to that provided under the Federal Employees Health Benefits Program (FEHBP). Low-income individuals not eligible for Medicaid or the State Children's Health Insurance Program (SCHIP) would receive subsidies to help finance coverage, either for the government-run plan or private coverage through a national exchange.

Similarly, in November, Senate Finance Committee Chairman Max Baucus released a white paper outlining his vision for a reformed health care system. His agenda also would create a new government-run plan that would "abide by the same rules as private health insurance plans participating in the Exchange" with respect to benefits and premiums. Sen. Baucus' language leaves unclear the issue of whether the government-run plan would pay providers at Medicare reimbursement rates or the higher levels most private carriers pay, noting only that reimbursement would be determined "by balancing the goals of increasing competition and ensuring access for patients."

Current Status of "Competition" in Medicare: President Obama's budget includes a proposal to create "competitive bidding" for privately-run Medicare Advantage (MA) plans that offer benefits to seniors. However, an examination of both the Obama proposal and current law reveals that the playing field between MA plans and government-run traditional Medicare is far from level:

- The proposal requires MA plans to bid against each other—but traditional Medicare will not be required to compete.
- The proposal does nothing to modify traditional Medicare's in-built bias under current law, whereby seniors are automatically enrolled in traditional Medicare unless they choose otherwise—even if a higher quality and more affordable MA plan exists.

[1] Testimony of Douglas Elmendorf, Congressional Budget Office Director, before House Energy and Commerce Committee hearing on "Making Health Care Work for American Families," March 10, 2009.

- The proposal does not permit supplemental benefits offered to low-income seniors to "wrap-around" an MA plan offering—to obtain those extra benefits, seniors must enroll in the government-run plan.

Some Members may also view the double standards set by the Obama budget as evidence to oppose a government-run health plan, because Democrats are unlikely to create a truly level playing field for MA plans to compete against government-run Medicare.

Administrative Pricing and Cost Shifts: Traditional Medicare's other built-in bias lies in its administrative pricing structure, whereby reimbursement levels are set through legislative and bureaucratic formulae, where providers (both doctors and hospitals) may either accept or reject the government's price. This "take it or leave it" philosophy differs appreciably from private health insurance plans—and results in reimbursement rates to physicians and hospitals significantly lower than market norms. Testifying before the Senate Finance Committee, CBO Director Elmendorf noted that in 2006, Medicare physician reimbursement rates averaged 20% less than private insurance levels; for hospitals, the disparity was 30%. In Medicaid, the variation was even greater: a 40% gap in physician payment levels, and 35% for hospitals.[2]

The result of this lower reimbursement structure within government-run plans has been a rise in private health insurance premiums—as physicians and hospitals shift their costs from public payers to private ones. A recent study by the consulting firm Milliman found a total of nearly $89 billion in cost-shifting from Medicare and Medicaid on to commercial payers. As a result, families with private health insurance spend nearly $1,800 more per year—$1,512 in higher premiums (paid by both employers and employees) and $276 in increased beneficiary cost-sharing—to cover the below-market reimbursement levels paid by Medicare and Medicaid.[3] The study reveals the broad extent of the perverse cross-subsidization present between the private and government-run health insurance markets, which may lead many Members to be concerned about the implications of broadening such cost-shifting even further through creation of a government-run health insurance plan.

In addition, most Members believe that Medicare does not appropriately price all physician and hospital services—as both Democrats and Republicans have been quick to propose alterations to Medicare's pricing structure. For instance, the "stimulus" bill placed a moratorium on proposed changes to hospice reimbursement, and legislation last July delayed a scheduled reduction in physician reimbursement levels—while providing for a 21% cut in January 2010. If Members believe that physicians should not receive a 21% pay cut next January, then they may believe that traditional Medicare's pricing mechanisms serve as an inappropriate mechanism to compare the "efficiencies" of government-run plans, or to serve as the foundation for a new government-run health insurance plan.

Enrollment in a Government-run Plan: Actuaries at the Lewin Group compiled estimates for the potential enrollees in a government-run plan—coupled with the number of individuals who would drop and/or lose access to their current private health insurance. The scenarios vary based on whether the government-run plan would be open solely to small businesses of under 25 workers, the self-employed, and the residual insurance market (i.e. those without access to employer-sponsored coverage), as then-Senator Obama first proposed, or whether the plan would be open to all Americans, as both he and Chairman Baucus later suggested. Lewin also factored in the potential reimbursement levels such plans may offer, and developed three scenarios based on Medicare payment rates, reimbursement rates paid by private insurance, or a blend between the two.

According to the Lewin model, enrollment in private insurance would drop by at least 10 million individuals in all cases—and in the event of a government-run plan open to all, and offering Medicare-

[2] Testimony of Doug Elmendorf, Congressional Budget Office Director, before Senate Finance Committee on "Options for Expanding Health Insurance Coverage and Controlling Costs," February 25, 2009, available at http://www.cbo.gov/ftpdocs/99xx/doc9911/02-25-Health_Insurance.pdf (accessed March 2, 2009), p. 23.

[3] Will Fox and John Pickering, "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," (Milliman, December 2008), available online at http://www.bcbs.com/news/bluetvradio/cost-shift-study-2008/us-cost-shift-20081208.pdf (accessed March 2, 2009).

level reimbursement rates, would result in 118.5 million individuals dropping their private coverage.[4] Enrollment in the government-run plan would range from 17 million in the low estimate (limited eligibility, private reimbursement rates) to over 130 million—more than half the under-65 population—in the high estimate (open eligibility, Medicare reimbursement rates). Notably, in the scenarios where the government-run plan paid below-market reimbursement levels (either Medicare rates, or a blend of Medicare and private rates), total enrollment in the government-run plan exceeded the reduction in uninsured populations—suggesting that such a plan would focus primarily on cannibalizing enrollees by encouraging employers to drop their current health insurance offerings.[5]

Impact on Providers: The Lewin study also analyzed the impact of various reimbursement levels on providers' overall revenues. In cases where a government-run plan open to all reimbursed at Medicare payment rates, the reduction in uncompensated care costs caused by fewer uninsured Americans was outweighed by the tens of millions of individuals previously with private insurance switching (voluntarily or otherwise) to a government-run plan with much lower reimbursement levels. As a result, hospitals' total revenue plunged by nearly 5% ($36.5 billion), and physicians' total revenue declined by nearly 7% ($36.4 billion). Even if a government-run health plan reimbursed at a blend of private and Medicare payment rates, physicians' total revenue would decline by more than 3%—this despite tens of millions of newly insured patients lowering uncompensated care totals.[6]

While supporters of government-run health insurance may argue that the crowd-out figures showing vast movement from private health insurance to a government-run plan would represent the government's "efficiency" in delivering health care, many Members would cite the revenue impact on providers as evidence of the government's harmful and distortionary effects. Any scenario whereby provider revenues are ***reduced*** after an ***increase*** in the number of insured patients would by definition reflect a perverse intervention by government into the marketplace, and cause many Members concern that such developments could result in patients losing access to providers and/or poorer quality care.

Implications of Government-run Plan: A government-run health plan enrolling as many as 130 million Americans could have significant implications for the entire health sector, particularly given the market distortions the insertion of a government-run plan would create on existing insurance markets. Some of the adverse effects that could cause many Members concern include the following:

Employers Dropping Coverage and a Potential "Death Spiral": As noted above, the introduction of a government-run plan—particularly one that reimbursed at below-market rates—would result in significant dislocation of individuals currently covered under employer-sponsored or other insurance on to the government-run plan. As a result, higher cost increases could be passed on to those private insurance plans that remain—as providers attempt to shift even larger reimbursement disparities on to the remaining private payers—eventually driving all or most private health insurance plans out of the market. Specifically, the Lewin Group's analysis of a Commonwealth Fund proposal to establish a government-run plan noted hundreds of billions in savings for employers, largely "resulting from **the shift of employers to the public plan**"—in other words, businesses who currently offer coverage "dumping" their insurance plans and placing their employees on the government-run program.[7] Such a scenario would not only represent a break from then-Senator Obama's promise that "If you like the health insurance you have, you can keep it," but could transform the United States into a *de facto* single payer health care system similar to Canada and Britain.

Poorer Coverage and Access to Care: While some Democrats have touted "Medicare for All" as a possible avenue to achieve comprehensive health reform, many Members—and many Americans—might be concerned by the relatively paltry level of health insurance benefits that a government-run health plan would provide. Medicare has only provided full prescription drug benefits for three years—and still

[4] Lewin Group, "A Buy-in to a Public Plan," Presentation to Senate Finance Committee Republican Staff, December 5, 2008, available online at http://www.lewin.com/content/publications/OpeningBuyInPublicPlan.pdf (accessed March 21, 2009).
[5] Ibid.
[6] Ibid.
[7] Lewin Group, "A Path to a High Performance U.S. Health System: Technical Documentation," (Prepared for Commonwealth Fund, February 19, 2009), available online at http://www.lewin.com/content/publications/4010.pdf (accessed March 21, 2009), p. 25.

contains no caps on catastrophic out-of-pocket spending, unlike most employer plans and all plans associated with Health Savings Accounts (HSAs). Testifying before the Finance Committee, CBO Director Elmendorf noted that the Medicare benefit has an actuarial level of coverage about 15% lower than the standard employer-provided plan—one reason why only 17% of Medicare beneficiaries rely solely on Medicare coverage.[8] These statistics led one reporter to highlight the extra benefits Medicare Advantage plans provide "relative to bare-bones government plans"—meaning traditional Medicare.[9]

In most states, Medicaid plans provide even less attractive coverage to beneficiaries, as low provider payment rates, even when compared to Medicare plans, result in significant beneficiary access problems, particularly with respect to medical specialists. For instance, a recent Centers for Disease Control study found that Medicaid patients visit the emergency room at nearly twice the rate of ***uninsured*** patients—suggesting that a Medicaid card does not mean that beneficiaries are receiving adequate primary care.[10] Poorer Americans often prefer other forms of health insurance when compared to Medicaid; a study by the liberal Commonwealth Fund found that among individuals earning less than twice the poverty level, private insurance outnumbered Medicaid as the preferred method of health coverage by more than two-to-one.[11] Even Energy and Commerce Committee Chairman Waxman recently admitted that "it is highly unlikely that you are going to find any millionaires who would like to go on Medicaid"—raising the question of why a plan so unattractive to wealthy individuals constitutes an acceptable health insurance plan for millions of less affluent Americans who may have no alternative coverage option.[12]

Given the current state of Medicare and Medicaid, many Members therefore may be concerned that the creation of a government-run plan would result in as many as 118 million Americans losing coverage they have—and like—because their employers decide to "dump" their workers into an inferior, though much less costly, form of government coverage.

Fraud: Waste, abuse, and outright fraud have been endemic to government health programs for decades—a fact Chairman Baucus acknowledged in his November white paper, even as he advocated for a government-run health insurance plan. One former New York state investigator has asserted that as much as 40% of the state's Medicaid spending consisted of questionable or outright fraudulent claims.[13] For instance, the *New York Post* recently highlighted an investigation into a single provider who billed $1.2 million in allegedly fraudulent claims providing prosthetic eyes to individuals with normal eyesight—whereas the billing and claims systems of most private insurance plans would have prevented such claims from ever being paid.[14]

Similarly, a recent series of articles in *CQ Weekly* highlighted persistent problems with wasteful and fraudulent spending in the Medicare program. Official estimates place the amount of Medicare fraud in the tens of billions per year—but officials admit that the amount could be higher, reflecting frauds never detected.[15] As the head of the Justice Department's Miami anti-fraud task force notes, "Once you—or someone who wants to commit fraud—have patients with Medicare numbers, and those patients are

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[8] Elmendorf Finance Committee Testimony; America's Health Insurance Plans, "Low-Income and Rural Beneficiaries with Medigap Coverage," (February 2007), available online at http://www.ahipresearch.org/PDFs/FullReportLowIncomeRuralReportFeb2007.pdf (accessed March 21, 2009), Figure 1, p. 4.

[9] Vanessa Fuhrmans, "Cuts Await Medicare Insurers," *Wall Street Journal* February 26, 2009, available online at http://online.wsj.com/article/SB123560916922977285.html (accessed March 4, 2009).

[10] National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary (Hyattsville, MD, National Center for Health Statistics, August 2008), available online at http://www.cdc.gov/nchs/data/nhsr/nhsr007.pdf (accessed September 13, 2008), Figure 3, p. 3.

[11] Jennifer Edwards et al., "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care," (New York, Commonwealth Fund, August 2002), available online at http://www.cmwf.org/usr_doc/edwards_erosion.pdf (accessed March 4, 2009), Table 3, p. 7.

[12] Transcript of House Energy and Commerce Committee markup, January 22, 2009, lines 10251-52.

[13] Clifford Levy and Michael Luo, "New York Medicaid Fraud May Reach into Billions," *New York Times* July 18, 2005, available online at http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?_r=1 (accessed March 4, 2009).

[14] Carl Campanile, "Medicaid Cops Bare Eye-Popping 'Scams,'" *New York Post* February 23, 2009, available online at http://www.nypost.com/seven/02232009/news/regionalnews/medicaid_cops_bare_eye_popping_scams_156496.htm (accessed March 4, 2009).

[15] Alex Wayne, "Elusive, Expensive Target," *CQ Weekly* February 16, 2009, p. 349.

willing to cooperate with you, **you can commit any kind of fraud you want**."[16] Some Members may be concerned that a government-run health care plan would be ripe for similar incidence of widespread fraud—which would represent a waste of taxpayer dollars, while undermining the argument that government plans are more "efficient" than private health insurance.

Government Care Means Government Control: Government programs constitute nearly half of all health care spending, and increasing government's market clout still further may well lead to rationing of procedures as a way to contain costs. Such actions would be entirely consistent with the philosophy of OMB Director Peter Orszag, who as head of the Congressional Budget Office prepared a report supporting the use of cost effectiveness research to determine reimbursement levels in government plans, while admitting that "patients who might benefit from more-expensive treatments might be made worse off" as a result of policy changes that tie insurance reimbursement to cost-effectiveness criteria.[17] The federal government already imposes price controls on doctors, hospitals, and pharmaceutical companies—leading some Members to wonder when controls on patient procedures will follow.

Funding and the Status of Current Entitlements: According to last year's trustees report, Medicare currently faces unfunded obligations of nearly $86 trillion. That number will likely grow this year—and the projected exhaustion date for the Hospital Insurance (Part A) Trust Fund could be accelerated by as much as three years, to 2016. While the Administration asserts that Medicare's spiraling debt levels require comprehensive health reform in order to slow the growth of health costs, the Obama budget actually ***increases*** health spending—which many Members may be concerned would only exacerbate the current problem. Therefore, some Members may support resolving the long-term sustainability of current entitlements—saving Medicare first, while also reforming Medicaid, as models for the way to slow the growth in health costs—before creating any new government programs.

Conclusion: Many Members may be strongly concerned about the implications of creating a government-run health plan to "compete" against current insurance plans. While such a competition may sound appealing in theory, Members may be highly skeptical that a truly level playing field could ever exist between a government-run plan and other options—particularly when the government's prime efficiency consists of shifting costs on to private payers. The estimates of the more than 100 million Americans who could be placed into such a government-run plan would represent not government's "success" in a "competition" but the eradication of private health insurance by a government able to spend unlimited sums to compete against employers unable to bear the costs shifted upon them. Some Members may therefore view a government-run plan as the first step towards creating a government-run health care system where all Americans have access to a mediocre system—and therefore oppose its creation as both antithetical to our current system of government and likely to result in poor health care for millions of Americans.

Instead, many Members may support reforms to the current tax code that would equalize the tax treatment of health insurance to provide greater incentives for individuals to purchase coverage. Members may also support reforms permitting greater variety in insurance plans—encouraging innovation and allowing individuals to choose for themselves the plan that best meets their needs—as well as voluntary "premium support" offerings in current government-run programs like Medicaid that allow beneficiaries to use government dollars to purchase private health insurance. Through these and other similar proposals, Members may offer alternatives that provide choice of quality, affordable health insurance—while ensuring that doctors and patients, rather than government bureaucrats, determine treatment options for all Americans.

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[16] Alex Wayne, "Getting in Front of Health Fraud," *CQ Weekly* February 16, 2009, p. 344.
[17] Congressional Budget Office, "Research on the Comparative Effectiveness of Medical Treatments," (Washington, December 2007), available online at http://cbo.gov/ftpdocs/88xx/doc8891/12-18-ComparativeEffectiveness.pdf (accessed March 5, 2009), p. 15.